HODAP ASSESSMENT

(*If possible, answer the questions for every member of the household including the children unless specified otherwise*.

LAST NAME **FIRST NAME** **MI**

_____

DATE OF SERVICE_____
The date the client received either a rent check or mortgage payment assistance.

TYPE OF SERVICE

Mortgage Payment Assistance
Housing Down Payment Assistance
Property Tax Payment Assistance
Rent Payment Assistance
Utility Assistance

IS THE CLIENT SINGLE? **Yes / No**
(If the client **is not single** and **is part of a household** that is recieving service then you must try to answer the next four questions.)

HOW MANY INDIVIDUALS ARE IN CLIENT'S HOUSEHOLD?_____

HOUSEHOLD TYPE:

Female single parent
Male single parent
Married couple and child(ren)
Unmarried couple and child(ren)
Married couple without child(ren)
Unmarried couple without child(ren)
Related caregiver with legal custody
Related caregiver without legal custody
Unrelated caregiver with legal custody
Unrelated caregiver without legal custody
Extended Family
Other

HEAD OF HOUSEHOLD? **Yes / No**

RELATIONSHIP TO THE HEAD OF HOUSEHOLD?_____

SOCIAL SECURITY NUMBER _____ _____ _____
SSN DATA QUALITY CODE

Full SSN Reported
Partial SSN Reported
Don't Know or Don't Have SSN
Refused

DATE OF BIRTH (*MM/DD/YYYY)* _____

IS THE CLIENT HISPANIC/ LATINO **Yes / No**

RACE

American Indian or Alaska Native
Asian
Black or African-American
Native Hawaiian or Other Pacific Islander
White

SECONDARY RACE

American Indian or Alaska Native
Asian
Black or African-American
Native Hawaiian or Other Pacific Islander
White

SEX **Female** **Male**

VETERAN STATUS

No
Yes
Don't Know
Refused

STREET ADDRESS _____

CITY _____ **STATE**_____ **ZIP**_____

Zip data quality code

Full SSN Reported
Partial SSN Reported
Don't Know / Don't Have SSN
Refused

DISABLING CONDITION

No Don't Know
Yes Refused

Select yes if a client has a physical, mental, emotional or developmental disability, HIV/AIDS, or a diagnosable substance abuse problem that is expected to be of long duration and substantially limits the clients ability to live on his or her own.

(if YES) **DISABILITY TYPES**

Disability Type	Start Date	Is Condition Long-term
____ Alcohol Abuse	_____	Yes / No
____ Developmental	_____	Yes / No
____ Drug Abuse	_____	Yes / No
____ Physical / Medical	_____	Yes / No
____ Mental Illness	_____	Yes / No
____ Physical / Mobility Limits	_____	Yes / No
____ HIV / AIDS	_____	Yes / No

ANNUAL INCOME AMOUNT _____

(Answer only for head of household, for members in the household leave answer blank)

HOUSEHOLD COUNTY MEDIAN INCOME (CMI) PERCENTAGE

0 to 30% CMI
31 to 50% CMI
51 to 80% CMI
Over 80% CMI

INCOME AND SOURCE:

(Answer only for head of household, for members in the household leave answer blank)

Source	Amount of income	Date Income Began	Date Income Ended
No financial resources.			
Earned Income	_____	_____	_____
Unemployment Insurance .	_____	_____	_____
Supplemental Security Income or SSI	_____	_____	_____
Social Security Disability Income (SSDI)	_____	_____	_____
Food Stamps	_____	_____	_____
A veteran's disability payment	_____	_____	_____
Private disability insurance	_____	_____	_____
Worker's compensation	_____	_____	_____
(TANF) (W2)	_____	_____	_____
General Assistance (GA)	_____	_____	_____
Retirement income from Social Security	_____	_____	_____
Veteran's pension	_____	_____	_____
Pension from a former job	_____	_____	_____
Child support	_____	_____	_____
Alimony or Other spousal support	_____	_____	_____
Other source	_____	_____	_____